TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BON SECOURS AT HARBOUR VIEW

Respondent Name
FIRST LIBERTY INSURANCE CORP.

MFDR Tracking Number
M4-17-2536-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It's our contention that payment should be made pursuant to Virginia's charge-based prevailing community rate metric and not the Texas fee schedule."

Amount in Dispute: $9,137.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have no record of an appeal for this DOS.
This Medical Dispute was also received after time allocated for filing per TX Rule 133.307 . . ."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2015	Surgical Services, Procedure Code 29881	$9,137.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Virginia to an injured employee subject to a Texas Workers' Compensation insurance claim. The health care provider has requested medical dispute resolution in accordance with Texas Labor Code Section 413.031(a)(1), which entitles a health care provider to a review of medical services if payment is reduced or denied. Because the requestor has sought the administrative remedy provided in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes it has jurisdiction to decide the medical fee issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable division rules.
2. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is March 10, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 25, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.